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ABSTRACT

Learned helplessness often precedes depression. The elderly are more likely than the general population to be faced with uncontrollable events which may bring on learned helplessness. Intervention by gerontological counselors has been useful in reducing effects of helplessness. With pseudohelplessness, persons act helpless in order to control another person's behavior. It is important for counselors to enhance their clients' perceptions of personal control. The counselor can engender the feeling of promotion of choice and predictability. The counselor should explain psychotherapeutic goals to the client at the beginning of therapy. Counselors must eliminate any helplessness-engendering stereotypes about the elderly that they may have, or risk damaging the counselor/client relationship. Attributional counseling can be effective in helping clients identify problems within their control. Psychotherapy may seem overwhelming to the truly helpless client, who may be assisted early in therapy by planned successes in relatively undemanding situations. Clients should be helped to set realistic goals and modify unrealistic expectations. By the counselor's effective communication, the client should feel personal control of the therapy. Although the clinical needs of nursing home residents must be met, residents' independence should be encouraged. The paper includes a five-page list of references and an appendix providing a brief description of counseling techniques that have proven effective with older clients. (ABL)

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Helplessness, Pseudohelplessness and Psychotherapy

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ABSTRACT

The intent of this paper is to explore ways in which the foundations of learned helplessness theory can be applied in psychotherapy, both individual and group, with older clients. The concept of learned helplessness is reviewed, with particular emphasis on its relationship to depressive symptomotology, and the concept of "pseudohelplessness" as an alternative maladaptive response to perceived threat of loss of control is described. Several recommendations for enhancing clients' perceptions of control in psychotherapy are discussed, including a) promoting choice and predictability, b) eliminating helplessness-engendering stereotypes, c) promoting positive attributions and a sense of responsibility, d) providing early success experiences, e) modifying unrealistic goals and f) using control-enhancing communication skills. Special considerations for conducting psychotherapy in small groups and within the context of the long-term care facility are addressed.

Helplessness, Pseudohelplessness and Psychotherapy

Learned helplessness has become relatively well-accepted as a possible antecedent to depression in individuals of all ages. It is the elderly, however, who are believed to be most likely to be exposed to life events that can be perceived as uncontrollable, and who are therefore prime candidates for control-enhancing interventions (Schulz, 1980).

In response, a major focus of recent gerontological research has been on the development of strategies to reduce the negative consequences of learned helplessness and perceived loss of control in older individuals. The gerontology literature is now replete with demonstrations of therapeutic interventions which have been successful in reducing helplessness effects in the elderly. Most of these interventions, however, have been implemented at the institutional level in long-term care facilities, and specific techniques for reducing helplessness effects in older adults engaged in one-on-one counseling or small group psychotherapy have not been explored.

The purpose of this paper is to review the clinical outcomes of learned helplessness in the elderly and to describe how the control-enhancing principles identified in prior research can be applied to gerontological counseling and psychotherapy. Attention will also be paid to the "pseudohelpless" client and to special considerations for helplessness reduction in group settings and in institutional environments.

Clinical Implications of Learned Helplessness in the Elderly

Advocates of learned helplessness theory (Seligman, 1975; Abramson, Seligman & Teasdale, 1978) assert that self-perceptions of ability to control one's social and physical environment are crucial to the maintenance of

physical and psychological well-being. Any individual, regardless of age, exposed to uncontrollable circumstances will eventually learn that efforts to manipulate the environment are ineffective. This realization of non-contingency between personal response and environmental outcome ultimately leads to a learned state of "helplessness".

The motivational, cognitive and affective deficits observed in depressed individuals are also symptomatic of learned helplessness and, in fact, learned helplessness is proposed to be an antecedent of reactive depression (Seligman, 1975). The loss of self-esteem seen in depression is also frequently observed in learned helplessness, particularly if the individual engages in self-blame (Abramson et al., 1978). Not surprisingly, helplessness theorists also suggest that the intensity of depressive symptomatology experienced is a direct function of the aversiveness of the negative situation experienced or the extent of desire attached to a lost or ungained positive outcome, be it person, object or goal (Abramson et al., 1978).

Helplessness depression can be the end-result of exposure to any number of potentially stressful events that older individuals encounter (Schulz, 1976). According to helplessness theory, it is not so much the negative aspects of the situation itself that engender helplessness but the perceptions of loss of control arising from the situation. Diagnosis of a critical illness may precipitate helplessness, as may death of a loved one or involuntary relocation, particularly to an institutional environment (Schulz & Brenner, 1978). Even retirement may induce helplessness among individuals who do so involuntarily. Providing care for a loved one with Alzheimers's disease, or any other cognitive or physical disorder, is another physically and emotionally draining situation that can potentially result in learned helplessness and depression (Coppel, Burton, Becker & Fiore, 1985). For the

older individual lacking appropriate internal resources and external support systems, multiple, simultaneous losses may easily precipitate a decline into helplessness.

Helplessness theorists assert that, when learned helplessness and consequent depression occurs, the individual searches for a cause to which they can attribute their condition (Abramson et al., 1978). Causal attributions are also thought to be analyzed by the individual in terms of their perceived globality and stability of negative symptoms experienced. Global attributions for an aversive event are likely to result in generalization of helplessness symptoms, while stable attributions are expected to lead to chronic, persistent helplessness effects.

Several studies suggest that depressed individuals of all ages tend to make those causal attributions that are the most destructive. Exposure to a failure (or otherwise negative) experience is typically ascribed by the depressive to personal inadequacy (i.e. a global, stable cause), resulting in negative symptoms that the individual expects to be pervasive and unchangeable (Abramson et al., 1978). When asked to make causal attributions for twelve scenarios depicting affiliation or achievement situations with positive or negative outcomes, depressed college students made significantly more internal, global and stable attributions for negative consequences then did their non-depressed counterparts (Seligman, Abramson, Semmel & von Baeyer, 1979).

This presence of a depressive attributional style has been documented for children and adolescents (Miller & Seligman, 1980) and adult psychiatric inpatients (Raps, Reinhard & Seligman, 1980), but remains to be fully explored in an elderly population. Assuming, however, that major personality traits and coping styles remain relatively stable across the life span, (e.g. Shanan,

1983) it is a reasonably safe assumption that older depressives possess a similar attributional style compared to non-depressed older adults.

It should be noted that whether individuals actually make causal attributions for situations perceived to be uncontrollable has yet to be demonstrated with any degree of certainty. Causal attributional processes have been documented in convalescing heart attack patients (Rudy, 1980), victims of serious accidents (Buhlman & Wortman 1977), and bereaved individuals (Glick, Weiss, & Parkes, 1974). Thus, at least some individuals in uncontrollable, aversive situations do appear to make causal attributions.

The universality of causal attribution development in helplessness, however, has been questioned (Wortman & Dintzer, 1978; Zuroff, 1981). Helpless individuals may, instead of analyzing causal dimensions, focus on the aversive situation itself. In these cases, evaluating the expected generalizability and duration of the situation itself, not its causes, determines the extent of helplessness and depressive symptomatology. In a study of spouse caregivers of Alzheimer's patients, virtually all subjects agreed the cause of their spouse's unpredictable behavior and the disruption of their own lives was the dementing disease process (Coppel et al.,1985). Therefore, the researchers felt it was more appropriate and informative to look at the spouses' evaluations of environmental circumstances, rather than attributional style.

Alternately, Wortman & Dintzer (1978) suggest that it is neither the causal attributions or features of the situation itself that determine the extent and magnitude of helplessness effects, but the individual's attributions to his or her personal reactions in the situation. According to Wortman and Dintzer, whether individuals believe the cause of a negative event is

controllable or not is less predictive of helplessness than their perceptions of whether personal reactions and solutions are within their control.

Regardless of unresolved attributional issues, it is clear that the phenomenon of learned helplessness is an important concept for professionals who encounter the elderly in psychotherapeutic settings. The most obvious reason is that learned helplessness depression is a condition which takes its toll in human misery and suffering. Also, learned helplessness can exert a more subtle negative impact on the therapeutic relationship, by undermining clients' motivation to work cooperatively.

The classical picture of learned helplessness is one of passivity and withdrawal. In fact, in many instances, the listless, helpless older individual is viewed as an easygoing, compliant, "good" patient/client by staff (Taylor, 1979; Raps, Peterson, Jonas & Seligman, 1982), and his or her passive behavior is reinforced. However, it may also be that helplessness contributes to non-compliant, uncooperative behaviors. Successful physical or mental rehabilitation often requires that both practitioner and client/patient work together cooperatively to effect desired therapeutic outcomes. Older individuals entering a service setting with pre-conditioned helplessness may feel that personal efforts are futile and thus have little incentive to participate actively and cooperatively in treatment. If the client is unwilling to expend any effort, therapeutic goals will be sabotaged.

The Concept of Pseudohelplessness

Some individuals behave overtly in ways that appear to be helpless, but reflect "pseudohelplessness" rather than true learned helplessness. In pseudohelplessness, the individual uses complaints that he or she is helpless and unable to perform certain tasks or live up to expected responsibilities as a mechanism for, in actuality, strongly controlling the behaviors of others.

By pretending that they are helpless, pseudohelpless individuals are actually quite effectively manipulating their social environment to achieve desired outcomes, be they personal attention, avoidance of obligations, or having things done for them. Pseudohelpless individuals have not yet fallen into a true helplessness; rather, they are responding to a perceived threat to their sense of control and are in a state of psychological reactance (Wortman & Brehm, 1985).

> Case Study: C.D., 65, suffered from moderately advanced Parkinson's disease and had been a convalescent home resident for three months. Divorced and without close family, he had always been somewhat of a "loner". At first, in the institutional setting, he was withdrawn and depressed, but as he settled into the hospital routine, he became increasingly demanding and critical of nursing staff. Projecting his anger at his disease and at the external world, he refused to do many things of which he was capable, including using his walker and transferring himself in and out of bed. He was constantly pressing the call bell and demanding help for minor tasks well within his capabilities. His "helplessness", while almost total, was not at all based on a perceived non-contingency of efforts and outcome. Quite the contrary, he rapidly achieved his goal of making himself the center of attention, and finding a forum to express his anger.

White and Janson (1985) have proposed that people are often capable of exerting personal control without directly manipulating the environment. These techniques, which they designate as secondary control measures, involve such strategies as experiencing vicarious control through others or purposely relinquishing control (e.g. to fate, God, the doctors). Perhaps the pseudo-helpless behavior pattern can be added as another subtle method for gaining secondary control.

Reducing Helplessness in Counseling and Psychotherapy

If the psychological consequences of helplessness or pseudohelplessness are indeed destructive, professionals conducting psychotherapy and counseling will be working in the best interests of their older clients if they utilize principles, skills and strategies designed to enhance clients' perceptions of

personal control. In the remainder of the paper, such recommendations for control-enhancement will be discussed and will include a) promotion of choice and predictability, b) elimination of helplessness-engendering stereotypes, c) promotion of therapeutic attributions and a sense of responsibility, d) provision of success experiences early on in therapy, e) modification of clients' unrealistic goals for therapy, and f) use of control-enhancing communication skills.

a) Promotion of choice and predictability-- Schulz (1977) has effectively demonstrated how the provision of small, everyday choices can cause considerable improvement in the physical and mental health functioning of older adults, at least those residing in institutions. Similarly, Schulz (1977) found that providing predictability to older nursing home residents also conveyed positive effects, possibly because it offered them a secondary source of perceptions of control (White & Janson, 1980). The principles of predictability and choice can, in most instances, be introduced quite readily into the therapist-client interaction. To the extent that it is feasible, clients can be allowed some choice in terms of determining scheduled appointments and issues to be explored in session. At the onset of therapy, the counselor can instill a sense of predictability by carefully delineating psychotherapeutic goals and letting the client know what he or she can reasonably expect.

> Case Study: L. W., 72, a successful architect, had been in psychotherapy for anxiety, off and on, for over forty years. Analytic work usually focused on his relationship with a demanding father, whom L. W. had never been able to please. The client entered an outpatient clinic complaining of depression following retirement, but was discouraged about the potential for therapeutic improvement. He was given the option of a twenty-session cognitive therapy program, with the specific goal of alleviating retirement-related depression or a more open-ended approach, and he selected the former. Perceiving the cognitive approach as a chance to deal with a specific issue, he quickly learned the basic concepts and was able to alleviate depressive episodes with the new techniques. In a

follow-up interview after the twenty sessions, W. L. attributed the success of therapy less to the cognitive techniques per se, and more to the sense of control and optimism generated by a concrete, focused, jointly selected psychotherapeutic strategy.

b) Elimination of helplessness-engendering stereotypes-- This obvious prerequisite to the establishment of a productive client-therapist relationship is one that is, unfortunately, all-too-frequently overlooked. Rodin and Langer (1980) have asserted that negative labels by others tend to be incorporated in the self-image of the elderly, leading to lowered self-esteem and perceptions of control, as well as negative age-stereotyped behavior. The therapist who believes that elderly clients are less competent, powerful, and resourceful than younger clients will, no doubt, inadvertently promote this counter-therapeutic process. Condescending and infantalyzing statements and/or expectations on the part of the therapist will only exacerbate clients' feelings of inefficacy and worthlessness. The client's perceptions of personal control are further reduced with the realization that, despite their unique individual characteristics and regardless of how competently they behave, the therapist will continue to lump them into the singular category of "helpless, decrepit elderly". Avoidance of such destructive biases is essential in restoring clients' confidence and perceptions of control.

Case Study: G. L., 87, suffered from many physical complaints, was wheelchair bound, and as a result of a stroke, was somewhat aphasic. Nonetheless, he retained all of his cognitive faculties, despite the fact that he gave the physical appearance of being extremely frail and dependent. After his wife's death, he was forced to relocate to a board and care home, where well-intentioned activities personnel attempted to assist him in resolving his grief through engagement in the standard activities of bingo and current events, with limited results. It was several months before a perceptive staff member made the effort to determine what would constitute an individualized activities program geared to G.L.'s capacities and needs. A used typewriter was obtained; and G.L. slowly and carefully typed his memoirs of the First World War. With the chance to integrate his life experiences, he was able to live the final months of his life with a sense of purpose.

c) Promoting therapeutic attributions and a sense of responsibility- The reformulated learned helplessness theory suggests that some attributions for perceived loss of control have a more destructive impact than others. For example, global attributions for negative outcomes are thought to result in more pervasive symptomatology, generalizing to all areas of the individual's life. Stable attributions to a negative event lead to chronic, long-term and persistent symptoms.

Recently, Coppel et al. (1985) asked caregivers of spouses with Alzheimer's disease to make attributional evaluations for "an unpredictable, upsetting patient behavior" and "an upsetting personal life change due to spouse's condition". Subjects who considered the patient's disruptive behavior to be global were significantly more likely to be depressed than those who made specific attributions, although the stability dimension had no effect. For personal life change, both globality and stability were related to depression.

A careful distinction must be made between internal attributions that are self-blaming and destructive and those internal attributions which imply a personal willingness to accept responsibility. Self-blame attributions are thought to exacerbate helplessness and depression, but the personal taking of responsibility is generally therapeutic. Buhlman and Wortman (1977) found that severe accident victims who felt they were responsible for their disabilities (and possibly therefore their rehabilitation) coped better than those who made external attributions. In Langer and Rodin's well-known study (Langer & Rodin, 1976; Rodin & Langer, 1977), the administrator's encouragement of personal responsibility was associated with better physical and mental health functioning of elderly nursing home residents.

Since emerging evidence shows that certain types of attributional evaluations in helplessness are associated with more severe negative outcomes, one role of the counselor is that of facilitator of more therapeutic attributions in elderly clients experiencing negative life events. Sparacino (1978) has advocated the use of reattribution training in psychotherapy with the elderly, and there is at least some evidence that the redirection of harmful and inappropriate attributions is an appropriate intervention for older adults. Rodin and Langer (1980), for example, were able to increase levels of older adults' activities and reduce stress by changing their attributions for poor health and memory loss from personal, age-related causes to external, environmental causes.

Strong (1978) has suggested an attributional model of counseling that appears promising for use with the elderly, although its specific application to that age group remains to be tested. According to Strong, a key element in successful therapy is helping clients identify causes of personal problems that are within their control. By modifying attributions from causes that render clients ineffectual to those which ascribe power to the client, positive psychotherapeutic change can be achieved.

> Case Study: L. F., 55, was a primary care provider for her husband, who sustained a severe stroke at age 50. Two of her four children were still at home, and the disability of her husband caused significant changes in the entire family system. L.F.'s attributional style involved always taking full responsibility for her family, and she reacted to their problems with guilt and depression. These feelings were exacerbated when she tried, without success, to involve the family in family therapy. She saw this as another failure on her part. Only after intense therapeutic effort, in both individual and group settings, did L.F. begin to let go of her expectations that she could singlehandedly rehabilitate her husband, reconstruct her family, and better cope with the day-to-day requirements of her caregiving. With strong encouragement from other care providers, she was finally able to focus her energies into areas over which she did have some control, such as assisting her husband with his physical therapy and increasing pleasant events in her life.

d) Providing early successes-- Truly helpless geriatric clients may find themselves initially feeling overwhelmed and intimidated by the tasks and demands they believe are incumbent upon them in psychotherapy. If challenged to deal with a particular issue or make a major independent decision early on in therapy, the helpless individual may become even less responsive and retreat further into passive, dependent behavior. To avoid threatening situations, it may be necessary initially to proceed somewhat cautiously, encouraging smaller therapeutic changes at first, and gradually progressing to more complex issues and behaviors as the patient's confidence grows.

One way to instill such confidence may be through the provision of "success" experiences early in psychotherapy. The provision of early reinforcing experiences, supplemented with generous praise and reinforcement, may be necessary simply to motivate the helpless client to continue in therapy, much less restore his or her sense of effectiveness and reduce clinical symptoms of helplessness. Stafford and Bringle (1980) gave older women the opportunity to engage in a useful at-home task in order to "alter perceptions of control, competency and choice". The task, making two pillows for hospitalized children, was chosen as one with low demands and a high probability of success. Those who participated later reported significantly higher levels of desire to socialize and engage in activities than previously.

> Case Study: R. H., 67, lived approximately a mile from her elderly, demented mother, but provided as much daily care as most in-home caregivers. R. H. had never married, or even, in many ways, ever separated from her mother. The symbiotic relationship that had existed for decades became extremely destructive when the mother, as her dementia progressed, became intensely suspicious and critical. R. H. was able to discuss in therapy her need to separate emotionally from her mother and to integrate the fact of her mother's cognitive losses, but in vivo, she continously feel back into old patterns, attempting to reason with her mother, and ending up in tears. Therapy was slow, but very gradually R. H. was able to decrease the length and frequency of her visits to her mother, turning many aspects of her mother's care over to a home health agency. Equally importantly, through this gradual, rather than

abrupt, disengagement process, she was able to realize the connection between the lessened intensity of the relationship and her own growing sense of control over her life.

e) Modifying unrealistic expectations-- Learned helplessness can be reduced if, without disregarding the need for flexibility, realistic goals for psychotherapy are set and maintained. Clients who enter the therapeutic setting with expectations for outcomes that are unrealistically high (e.g. a widowed individual who feels therapy will help her find a new spouse), more appropriate goals must be established to avoid the eventual onset of disappointment, disillusionment and even further helplessness. More typically, the helpless individual will feel there is very little to be gained from psychotherapy and will have unrealistically low expectations for what can be accomplished. In these cases, it becomes the therapist's challenge to convince the individual that, given a mutual effort, certain positive outcomes can be expected to occur. On a case-by-case basis, the therapist must find ways to instill sufficient hope in the client, so that the therapeutic relationship is perpetuated.

Case Study: R. A., 64, entered an outpatient depression clinic with vague complaints of feeling that life had passed him by. He would bring on depressive episodes by obsessing over past failures and missed opportunities. Having never been in therapy, he had an expectancy set of a "magic cure" and resisted doing any structured out-of-therapy work. Depsite six months of therapy, R. A. never fully engaged in a meaningful therapeutic alliance, and finally terminated with the same sense of lack of control over his feelings with which he had entered counseling.

f) Control-enhancing communication skills-- The process of enhancing a client's perception of control in-session is grounded in the work of interpersonal therapy (Kiesler, 1982). A basic principle of interpersonal therapy is that two people in a therapeutic relationship both influence the other. Helpless individuals, relating to others in a submissive, distancing manner, "pull" from others both dominance responses and reciprocal distance,

thus reinforcing helplessness and dependency. Therapists who are able to alter this interpersonal pattern and provide helpless clients with some sense of interpersonal control in-session lay the groundwork for the relearning of efficacy and control in other areas of life.

Communications aimed at demonstrating the therapist's respect and concern for the client may be used to elevate clients' perceptions of personal control within the therapeutic setting. Specific communication skills which indicate that the client is having an impact on the therapist and on the interaction itself (e.g. responding to affect, using open-ended questions, being genuine, concrete and immediate) can be used to reduce clients' learned helplessness. One set of specific skills which has been successfully taught to service providers for the elderly by Priddy, Teitelman, Kivlighan and Fuhrmann (1982) is offered as an example (see Appendix).

Control-Enhancing Interventions in Small Groups

Many core psychological issues of later life, such as isolation and loss, are particularly amenable to group interventions. Both self-help groups (Lieberman, 1985) and psychotherapy groups (Parham, Priddy, McGovern & Richman, 1982) have proven effective with the elderly. Older persons perceiving a noncontingency between their efforts and outcome, however, are more difficult to enroll in groups, and are less likely to engage in group process when they do attend.

Self-help groups for caregivers and widowed individuals focus on information and interpersonal support. "Helpless" individuals, initially, may not perceive these factors as relevant for them, and recruitment into such groups may prove difficult. Assistance perceived as "psychotherapeutic", is especially difficult to market to older adults. For volunteer community-based groups in particular, recruitment of the "helpless" older person is more

usually difficult, and engagement in the group process frequently develops more slowly.

Group leaders working with older persons experiencing learned helplessness will have to exert much more initial effort to engage these individuals, and participation will have to be made as nonthreatening as possible. Facilitators may be required to coordinate issues such as transportation and scheduling for persons unwilling to do so, and small, positive group experiences should be integrated early into the course of treatment. Group work with both the elderly, helpless or not, may benefit by a transition from an early, structured format to a more open, process-oriented approach (Davies, Priddy & Tinklenberg, in press). As group work develops, helpless elderly will learn that they indeed do have an impact within the group setting, and will observe others successfully using their own resources to solve problems and deal with issues of control. The helpless older person is a difficult challenge to the group facilitator, but groups provide a powerful opportunity to develop positive perceptions of control of the environment and attributions of personal efficacy.

Control-Enhancing Interventions in Nursing Homes

Designing and conducting control-enhancing interventions and psychotherapy programs for that minority of elderly individuals residing in long-term care facilities warrants special attention and requires two major special considerations. First, within the context of the institutional environment, efforts towards self-efficacy are not likely to be reinforced and therefore may not be the most adaptive response (White & Janson, 1984). Also, the development of a control-enhancing program without plans for long-term continuation may do residents more harm than good (Schulz & Hanusa, 1978).

Although great strides have been made in some nursing homes to promote residents' independence and efficacy, the institutionalized aged, compared to their community-dwelling peers, typically perceive themselves as exerting low levels of environmental control (Hulicka, Morganti & Cataldo, 1975; Morganti, Nehrke & Hulicka, 1980). There is preliminary evidence that the process of institutionalization itself actually causes a decline in older residents' perceptions of control (Arling, Harkins & Capitman, 1984). Certainly, it has been clearly demonstrated that, within the context of nursing home life, residents' dependent behaviors tend to be reinforced by staff, and their efforts towards independent behavior go primarily unsupported (e.g. Baltes, Honn, Barton, Orzech & Lago, 1983).

Nursing home staff are often motivated by their well-intentioned efforts to protect and "do for" residents in their care. It has been shown, however, that excess levels of staff "helpfulness" can contribute to residents' "helplessness" (Avorn & Langer, 1983). In Avorn and Langer's (1983) study, older nursing home residents receiving direct help on a jigsaw-puzzle solving test performed significantly more slowly and poorly than residents receiving only encouragement or no intervention. Furthermore, those receiving encouragement perceived the task as less difficult and reported higher levels of confidence ($p < .06$) than those receiving direct aid. Avorn and Langer concluded that, while the very real clinical needs of the institutionalized elderly must continue to be supported, overprotectiveness can result in residents' dependence and helplessness.

Given the reality that these constraints often do occur in institutional environments, White and Janson (1984) have hypothesized that relinquishing efforts to control the nursing home environment may, in fact, be a rational and adaptive response. In facilities where situational constraints are

severe, it may be countertherapeutic to encourage residents to believe they are in control.

White and Janson (1984) assert that a distinction must be made between residents' use of primary and secondary control behaviors. Primary control involves direct attempts to manipulate the environment, while secondary control involves such strategies as the deliberate and purposeful relinquishment of control to an outside source (e.g. God, the doctors) and the vicarious experience of power through the actions of others, (or as hypothesized earlier in this paper, the use of "pseudohelpless" behavior). According to White and Janson, the institutional environment may make primary control impossible and unrealistic; secondary control mechanisms, in contrast, may be a more feasible, adaptive alternative for residents. While this specific hypothesis requires further field testing, it remains quite clear that any efforts to promote residents' control through psychotherapeutic programs will be sabotaged if the environment is not supportive of residents' independence. In developing any such program in a long-term facility, this reality must be considered.

Schulz and Hanusa (1978) have also warned that developing control-enhancing interventions without provisions for long range continuation can be more harmful to residents' well-being than simply introducing no interventions whatsoever. In a follow-up analysis of Schulz's (1977) study, Schulz and Hanusa (1978) reported that nursing home residents whose expectations for control were raised, following their opportunity to control students visits, had significantly poorer levels of functioning after termination of the visitation program than those who received no visits or random visits. It is neither humane nor ethical to first offer a temporary measure to elevate expectations for control, then abruptly remove it. Before developing

interventions, researchers, psychotherapists and nursing home staff must assess to what degree they are willing to commit themselves to carrying out the program on a long-term basis.

Summary

The concept of learned helplessness has been well established as relevant to the problems of many older adults. This paper has attempted to raise issues pertinent to the transfer of learned helplessness theory from the realm of experimental research to actual clinical practice. As discussed, not all helpless behavior is "learned helplessness", and learned helplessness may clinically manifest itself in many forms. Therapists working with older adults need to be aware of the dynamics of learned helplessness, its various manifestations, and the therapeutic implications of these manifestations. More clinical research is required to assess the effectiveness of interventions designed to alleviate helplessness; and this research needs to be founded on a dialogue between social science researchers and clinicians, much as early work in learned helplessness was based on a collaboration of ideas in animal research and social psychology. Through such cooperative endeavors, we may eventually reach the ultimate goal of truly effective psychotherapeutic efforts with distressed older adults.

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APPENDIX

(Workshop Handout; Priddy, Teitelman, Kivlighan & Fuhrmann, 1979)©

COUNSELING TECHNIQUES

The following counseling techniques have proven effective in working with older clients experiencing learned helplessness. In each instance, the counselor's response allows the client to perceive the effect of his/her statements, feelings, etc., on the helper, thereby increasing the person's sense of impact.

RESPONSE TO AFFECT

There are two basic components of any communication: content and affect, or feeling. Responding to the content component leads to a cognitively oriented interaction. Responding to affect encourages the client to explore his/her feelings.

Feelings dictate behavior. If a client's emotional state is blocking his/her progress, no amount of cognitive information will be helpful. The effective helper should be comfortable in talking about feelings, and willing to share of his/her own emotional reactions. When the client perceives that the counselor knows how he/she feels, the foundation is laid for a productive relationship of mutual trust.

Many clients proceed through an entire session, or series of sessions, and deal solely with facts, without ever talking about feelings. Any life change that brings an older person to a helper will have an affective component. The effective helper recognizes the importance of focusing on the emotional aspect of the client's world, and is able to assist the person in getting in touch with his/her feelings. If these feelings include helplessness, an empathic counselor response may serve to let the older person begin to be aware that his/her feelings have impact on others.

OPEN-ENDED QUESTIONS

There are basically two types of questions: "open-ended" and "close-ended". A close-ended question gives the older person limited ability to respond, often eliciting a simple "yes" or "no", while an open-ended question encourages the client to provide more data.

A good way to check out the effectiveness of one's questions is to analyze who is providing the information. With open-ended questions, the counselor facilitates the older person's development of an idea, and the

client is free to provide whatever information he or she feels is relevant, and to focus on things most important to him or her. A helper who is too directive frequently dictates the entire focus of interactions, and clients may or may not get what is important to them. Consequently, the older person feels that he/she has little or no control over the interaction. The effective counselor is flexible and responsive to the needs of the client, and employs an open-ended format to allow the client to have a maximum amount of input.

GENUINENESS

Genuineness involves being one's self without facade. The genuine person is aware of his/her own feelings, and deals with them directly and openly. He/she is never "phony", and does not change when he/she is with different people. Bring genuine involves being spontaneous, non-defensive, self-disclosing; in short, being open and natural. Clients will not respond to helpers perceived as devious, manipulative or artificial.

CONCRETENESS

Concreteness is a willingness to talk specifically about feelings, thoughts and behaviors. Generalized discussions and vague solutions to vaguely defined problems will not lead to effective action. Boring, rambling counseling sessions are indicators of a lack of concreteness. The vagueness may seem "safe" to the client (and the helper), but it is not productive.

IMMEDIACY

Immediacy is a direct one-to-one communication about the here-and-now. Egan (1975) postulates that all client problems are rooted in interpersonal difficulties, and that looking at the interpersonal relationship between the counselor and the client is one way of examining these difficulties. An immediacy statement allows the client to receive direct, immediate feedback on his/her impact on the helper. This form of communication requires a high level of counselor self-awareness and skill.

Immediacy statements should be offered as tentative hypotheses, and topics for discussion, not as criticisms or defenses. It is essential that the counselor be accurate in her/her perception, and to have a purpose in introducing the shift in focus. Genuineness (being one's self) is a pre-requisite for immediacy.